MEDICARE+CHOICE: CHANGES FOR THE YEAR 2000
EXECUTIVE SUMMARY

Since the creation of Medicare+Choice (M+C) in 1997, the Health Care Financing Administration (HCFA) has been working continuously to ensure that there is a wide range of high-quality health care options available to Medicare beneficiaries and to improve the operation of M+C for the private companies that choose to serve them. As part of this effort, HCFA has devoted a significant amount of time and effort to developing a better understanding of the program's successes and shortcomings. This report represents our latest effort to help Congress, the managed care industry, interested parties, and --most importantly-- Medicare beneficiaries and their advocates to understand how M+C is evolving.

BENEFICIARY ENROLLMENT AND MANAGED CARE ORGANIZATION PARTICIPATION

- *Beneficiary Enrollment* -- Total Medicare managed care enrollment has more than doubled in the past four years, from 3.1 million at the end of 1995 to 6.3 million in 1999. Approximately 33 million beneficiaries are in traditional fee-for-service Medicare.

- *Plan Participation* -- Plan participation has been somewhat volatile over time. In fact, the highest rate of increase in participating organizations (almost 40 percent) since 1986 occurred in 1994. The largest rate of decrease occurred in 1990 (almost 30 percent.) For both the 1999 and 2000 contract year, approximately 13 percent of the contracts were not renewed.

MEDICARE+CHOICE IN THE YEAR 2000 -- CHANGES IN EXTRA BENEFITS OFFERED

Although beneficiary access to prescription drugs and other non-Medicare benefits offered by M+C plans will remain relatively constant, many plans will restructure drug benefits in ways that increase enrollee out-of-pocket costs and limit drug coverage.

- *Drug Caps* -- In 2000, 86 percent of plans will have annual dollar limits (caps) on brand and/or generic drugs. The annual caps are becoming more restrictive. In 1999, only 21 percent of plans had an annual cap on drugs of $500 or less; in 2000, 32 percent of plans will have a $500 per enrollee benefit spending cap. Although enrollees will be more likely to have access to unlimited generic drug coverage, they will also be more likely to have even tighter caps imposed on brand-name drugs.

- *Copayments* -- There will be increased use of copays for prescription drugs. In fact, for the first time, all M+C organizations will charge copays for prescription drugs. In 1999, over one million beneficiaries live in areas with zero copayments for generic and brand name drugs. In

2000, all beneficiaries will live in areas with copays on both types of drugs. On an enrollment-weighted basis that assumes M+C enrollment levels will remain constant from 1999 to 2000 and that different M+C organizations will maintain their same proportion of enrollees, average copays for brand-name drugs would increase by 21 percent, with average copayments for generic drugs increasing by 8 percent.[1]

- *Access to Extra Benefits Varies by State* -- Nationally, the number of beneficiaries with access to an M+C plan offering some prescription drug coverage will remain virtually unchanged next year. However, there will be state variation. Several states will have a substantial decrease in the number of beneficiaries with access to at least one M+C plan that provides a drug benefit. These states include Iowa, North Carolina, Nebraska, and Delaware. At the same time, a few states will have increased availability of drugs in 2000, including Virginia, New Hampshire, and Washington

MEDICARE+CHOICE IN THE YEAR 2000 -- CHANGES IN PREMIUMS

- *Increase in Premiums* -- For the M+C program overall, there will be an increase in the level of monthly premiums. For example, in 1999 on an enrollment-weighted basis, the average monthly premium for basic plans was $5.35. For 2000, this amount would almost triple to $15.84. Moreover, in 2000, the number of beneficiaries for whom the lowest available premium will be in the $20 to $60 range will increase by approximately 50 percent over 1999. Of the 207,000 beneficiaries who live in areas where the minimum monthly premium available is over $80, 94 percent (over 195,000) live in areas with only one plan available.

- *Decline in Plans with Extra Benefits for No Premium* -- In 2000, there will be a decline of about 3 million in the *number* of Medicare beneficiaries with access to a plan that does not charge for a premium for enrollment. This represents a decrease in the *percentage* of beneficiaries with access to any plan that does not charge a premium, from 85 percent in 1999 to 77 percent in 2000.

MEDICARE+CHOICE IN THE YEAR 2000 -- WITHDRAWALS AT THE END OF 1999

- *Plans Withdrawing From the Program* -- Over the past two years, a small percentage of beneficiaries have been affected by M+C withdrawals. In 1999, 407,000 enrollees (6.5 percent of M+C enrollees at the time in 1998) were affected, with approximately 51,000 (less than one percent of enrollees) being left without the option of enrolling in another M+C plan.

---

[1] As with all the enrollment-weighted analyses, this assumes that M+C enrollment levels will remain constant from 1999 to 2000 and that different M+C organizations will maintain their same proportion of enrollees. Due to this assumption, HCFA refers to changes shown by this analysis as those that "would" (as opposed to will) occur.

Approximately half of beneficiaries affected by the withdrawals who still had an M+C option chose original fee-for-service Medicare and the other half chose to enroll in another organization.

For 2000, there were 327,000 enrollees affected (5 percent of M+C enrollees) and 79,000 (1.3 percent of enrollees) left with no M+C option. These beneficiaries were enrolled in 99 separate organizations that either withdrew entirely from the program or reduced their service area.

- *New Plan Approvals Will Help Improve Access* -- Despite volatility in the overall managed care marketplace, new organizations continue to come into the program. Since July 1998, 42 organizations have been approved for participation or expansion in the program affecting 400,000 beneficiaries in 87 counties. Of the 400,000 beneficiaries, 47 percent (approximately 200,000 beneficiaries) are residents of rural areas; of the 87 counties, 84 percent are rural. As of August 1999, there are 13 pending applications from organizations seeking new M+C contracts and nine requests for service areas expansions. Over 50 percent of the counties included in these pending applications currently have no M+C plans.

- *Access to Plans Reduced Slightly* -- As a result of terminations and service area reductions, overall access to M+C options will decline slightly in the year 2000, as it did in 1999. The trend of the decline in beneficiaries who had access to one or more M+C organizations has been slightly negative --in 1998, 72 percent of had such access; in 1999, the percentage declined to 71 percent; and for 2000 the percentage declined to 69 percent.[2]

- *Revenue and the Relation to Non-Renewal Decisions* -- Withdrawals of organizations from M+C are not primarily occurring in the lowest payment areas. They are disproportionately withdrawing from counties where payment rates are in a mid-range of $451 and $500 for the year 2000. If payment were the primary factor, one might expect withdrawals to be focused in counties with the lowest payments. Only 4 percent of enrollees in counties with the minimum payment level ($401) were affected. Yet, 12 percent of enrollees in counties with payments in the higher range of $451 to $500 were affected. Similarly, withdrawals do not appear to be correlated with low payment growth rates. Plan withdrawals will affect 7.2 percent of enrollees in counties where M+C payment rates are rising by 10 percent or more, but only affect 2.4 percent of enrollees where rates are rising by the 2 percent minimum.

---

[2] The year 2000 figure is based on currently approved plans. The percentage will increase as new plan applicants enter the program.

MEDICARE+CHOICE IN THE YEAR 2000 -- PARALLELS TO PRIVATE SECTOR

- *The M+C Experience Corresponds to the Private Sector Experience* -- Program withdrawals, reduced benefits, and premium increases are not unique to Medicare. They reflect the industry-wide difficulty organizations have faced in the last few years in controlling costs while attempting to maintain quality and profit levels.

- *Factors Other than Payment Leading to Non-Renewal Decisions* -- Overall, the facts suggest that the General Accounting Office's findings about withdrawals for the 1999 contract year still hold true: causes other than payment rates appear to play a large role in business decisions to participate in M+C in 2000. Among the factors that appear to be relevant in both 1999 and 2000 are M+C enrollment levels in each contract, share of the local M+C market, the ability to maintain adequate provider networks, as well as strategic business decisions specific to a given organization.